

HMIS Project Intake Form

HOPWA

Step 1: Universal Data Collection

Please complete the following basic client information and note that all fields with an * are required fields. Universal Data Elements are required for all project participants. The response "Data Not Collected" means the question was not asked of the client and will report as missing on reports.

Basic Client Information:*

First Name: * _____ Last Name: * _____

Middle Name: _____ Suffix: _____

Name Data Quality:* <input type="checkbox"/> Full Name Reported <input type="checkbox"/> Partial, Street Name or Code Name Reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	Social Security Number:* <input type="checkbox"/> _____ <input type="checkbox"/> Full SSN Reported <input type="checkbox"/> Approximate or Partial SSN Reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	Birthdate:* _____ <input type="checkbox"/> Full DOB Reported <input type="checkbox"/> Approximate or Partial DOB Reported <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected
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Ethnicity:* <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	Race:* <i>(Select All That Apply)</i> <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	Gender:* <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Client Doesn't Identify Male, Female or Transgender <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected
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If Female, Pregnancy Status:*

☐ Yes
 ☐ Due Date: _____

☐ No
☐ Client Doesn't Know
☐ Client Refused
☐ Data Not Collected

Disabling Condition:* <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	Veteran Status:* <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	Relationship to Head of Household:* <input type="checkbox"/> Self <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Dependent Child <input type="checkbox"/> Spouse <input type="checkbox"/> Foster Child <input type="checkbox"/> Grandchild <input type="checkbox"/> Other Family Member <input type="checkbox"/> Other Non-Family Member
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Contact Information:

Address: _____ City/State/Zip: _____

Email: _____ Home Phone: _____

Work Phone: _____ Message Phone: _____

Step 2: Project Enrollment

Complete the project enrollment information and please note all fields with an * are required fields. Complete additional forms for each household member to be enrolled.

Assessment Date:* _____

Case Assignment:* _____

Step 3: Entry Assessments

Complete the following entry assessments and please note all fields with an * are required fields.

Housing Status* (*Based on housing condition just prior to project entry*)

- | | |
|--|--|
| <input type="checkbox"/> Category 1 – Homeless | <input type="checkbox"/> Stably Housed |
| <input type="checkbox"/> Category 2 – At Imminent Risk of Losing Housing | <input type="checkbox"/> Client Doesn't Know |
| <input type="checkbox"/> Category 3 – Homeless Only Under Other Federal Statutes | <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> Category 4 – Fleeing Domestic Violence | <input type="checkbox"/> Data Not Collected |
| <input type="checkbox"/> At Risk of Homelessness | |

Type of Residence:* (*Living situation just prior to project entry*)

HOMELESS SITUATION

- ☐ Place not meant for habitation (a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)
- ☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher
- ☐ Safe Haven
- ☐ Interim Housing (*housing situation where a chronically homeless person has applied for permanent housing, been accepted and housing reserved, but unit is not yet available*)

If the client's type of residence is a homeless situation, answer the following questions:

Length of stay in the prior living situation:*

- ☐ One night or less
- ☐ Two to six nights
- ☐ One week or more, but less than one month
- ☐ One month or more, but less than 90 days
- ☐ 90 days or more, but less than one year
- ☐ One year or longer
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

Approximate date homelessness started:* _____

Type of Residence:* (*Living situation just prior to project entry*)

INSTITUTIONAL SITUATION

- ☐ Foster care home or foster care group home
- ☐ Hospital or other residential non-psychiatric medical facility

- ☐ Jail, Prison or Juvenile Detention Center
- ☐ Long-term care facility or nursing home
- ☐ Psychiatric Hospital or Other Psychiatric Facility
- ☐ Substance Abuse Treatment Facility or Detox Center

If the client's type of residence is an institutional situation, answer the following questions:

Did you stay less than 90 days:*

☐ Yes

☐ No

If Yes, then length of stay in the prior living situation:*

If No, then length of stay in the prior living situation:*

☐ One night or less

☐ 90 days or more, but less than one year

☐ Two to six nights

☐ One year or longer

☐ One week or more, but less than one month

☐ Client Doesn't Know

☐ One month or more, but less than 90 days

☐ Client Refused

☐ Client Doesn't Know

☐ Data Not Collected

☐ Client Refused

☐ Data Not Collected

On the night before did you stay on the streets, ES or SH:*

☐ Yes, approximate date homelessness started: _____

☐ No

☐ Client Doesn't Know

☐ Client Refused

☐ Data Not Collected

Type of Residence: * *(Living situation just prior to project entry)*

TRANSITIONAL AND PERMANENT HOUSING SITUATION

- ☐ Hotel or motel paid for without emergency shelter voucher
- ☐ Owned by client, no ongoing housing subsidy
- ☐ Owned by client, with ongoing housing subsidy
- ☐ Permanent Housing for Formerly Homeless Persons (a CoC project; HUD legacy programs; or HOPWA PH)
- ☐ Rental by client, with no ongoing housing subsidy
- ☐ Rental by client, with VASH housing subsidy
- ☐ Rental by client, with GPD TIP subsidy
- ☐ Rental by client, with other ongoing housing subsidy
- ☐ Residential project or halfway house with no homeless criteria
- ☐ Staying or living in a family member's room, apartment or house
- ☐ Staying or living in a friend's room, apartment or house
- ☐ Transitional Housing for Homeless Persons (Including Homeless Youth)
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

If the client's type of residence is a transitional or permanent housing situation, answer the following questions:

Did you stay less than 7 nights?:*

☐ Yes

☐ No

If Yes, then length of stay in the prior living situation:*

☐ One night or less

☐ Two to six nights

☐ One week or more, but less than one month

☐ One month or more, but less than 90 days

☐ Client Doesn't Know

☐ Client Refused

☐ Data Not Collected

If No, then length of stay in the prior living situation:*

☐ One week or more, but less than one month

☐ One month or longer, but less than 90 days

☐ 90 days or more, but less than one year

☐ One year or longer

☐ Client Doesn't Know

☐ Client Refused

☐ Data Not Collected

On the night before did you stay on the streets, ES or SH:*

☐ Yes, approximate date homelessness started: _____

☐ No

☐ Client Doesn't Know

☐ Client Refused

☐ Data Not Collected

Only answer the next two questions if client's type of residence was a homeless situation or if client stayed on the streets, in an ES or SH on the night before.

Regardless of where they stayed last night – number of times the client has been on the streets, in ES, or SH in the past three years including today:*

☐ One Time

☐ Client Doesn't Know

☐ Two Times

☐ Client Refused

☐ Three Times

☐ Data Not Collected

☐ Four Times

Total number of months homeless on the street, in ES, or SH in the past three years:*

☐ One month (this time is the first month)

☐ Client Doesn't Know

☐ 2-12 months

☐ Client Refused

☐ Number of months (2-12):* _____

☐ Data Not Collected

☐ More than 12 months

Covered by Health Insurance:*

- | | | |
|--|--|--|
| <input type="checkbox"/> Yes | If Yes, Type:* | <input type="checkbox"/> Military Insurance |
| <input type="checkbox"/> No | <input type="checkbox"/> Private - COBRA | <input type="checkbox"/> Other Public |
| <input type="checkbox"/> Client Doesn't Know | <input type="checkbox"/> Private – Employer | <input type="checkbox"/> State Funded (HIP or HIP 2.0) |
| <input type="checkbox"/> Client Refused | <input type="checkbox"/> Private – Individual | <input type="checkbox"/> Indian Health Service (Native American) |
| <input type="checkbox"/> Data Not Collected | <input type="checkbox"/> Medicare | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Medicaid | |
| | <input type="checkbox"/> State Children's Health Insurance Program (S-CHIP; not Medicaid or HIP) | |

Status:*

- | | | |
|--|---|--|
| <input type="checkbox"/> Active | <input type="checkbox"/> No | |
| <input type="checkbox"/> Start Date: _____ | <input type="checkbox"/> Applied; decision pending | <input type="checkbox"/> Client Doesn't Know |
| <input type="checkbox"/> End Date: _____ | <input type="checkbox"/> Applied; client not eligible | <input type="checkbox"/> Client Refused |
| | <input type="checkbox"/> Client did not apply | <input type="checkbox"/> Data Not Collected |
| | <input type="checkbox"/> Insurance type N/A for this client | |

Veterans Assessment:*

Military Branch:*

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> Army | <input type="checkbox"/> Client Doesn't Know |
| <input type="checkbox"/> Air Force | <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> Navy | <input type="checkbox"/> Data Not Collected |
| <input type="checkbox"/> Marines | |
| <input type="checkbox"/> Coast Guard | |

Discharge Status:*

- | | |
|--|--|
| <input type="checkbox"/> Honorable | <input type="checkbox"/> Uncharacterized |
| <input type="checkbox"/> General under honorable conditions | <input type="checkbox"/> Client Doesn't Know |
| <input type="checkbox"/> Bad Conduct | <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> Dishonorable | <input type="checkbox"/> Data Not Collected |
| <input type="checkbox"/> Under Other Than Honorable Conditions (OTH) | |

Service Entry Date: * _____ Service Exit Date: _____

Select Theatre(s) of Operation(s):* (May not apply to client)

- ☐ World War II (September 1940-July 1947)
- ☐ Vietnam War (August 1964-April 1975)
- ☐ Persian Gulf War (Operation Desert Storm) (August 1991-September 10, 2001)
- ☐ Afghanistan (Operation Enduring Freedom)
- ☐ Iraq (Operation Iraqi Freedom)
- ☐ Iraq (Operation New Dawn)
- ☐ Other Peace-keeping operations or military interventions (such as Lebanon, Panama, Somalia, Bosnia, Kosovo)
- ☐ Korean War (June 1950-January 1955)

Status:*

- ☐ Yes
- ☐ No
- ☐ Client Doesn't Know
- ☐ Client Refused
- ☐ Data Not Collected

<u>Barriers:*</u>	<u>Barrier Present?</u>	<u>Receiving Services/Treatment?</u>	<u>Condition Indefinite?</u>	<u>Documentation on File?</u>
Alcohol Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No
Developmental Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No
HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mental Health	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Health Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No

HMIS Barriers Assessment:*

If client reports "Alcohol Abuse, Drug Abuse and/or Mental Health" as present barriers, complete the following:

How confirmed:

- ☐ Unconfirmed; presumptive or self-report
- ☐ Confirmed through assessment and clinical evaluation
- ☐ Confirmed by prior evaluation or clinical records

Domestic Violence Assessment of Victim:*

Is client a victim of domestic violence:*

- | | |
|--|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Client Doesn't Know | <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> Data Not Collected | |

Currently Fleeing:*

- | | |
|--|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Client Doesn't Know | <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> Data Not Collected | |

If yes, when experience occurred:*

- | |
|--|
| <input type="checkbox"/> Within the past three months |
| <input type="checkbox"/> Three to six months ago (excluding 6 months exactly) |
| <input type="checkbox"/> Six months to one year ago (excluding 1 year exactly) |
| <input type="checkbox"/> One year ago or more |
| <input type="checkbox"/> Client Doesn't Know |
| <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> Data Not Collected |

Medical Assessment:*

Medical Assistance Type:*

- | |
|---|
| <input type="checkbox"/> Receiving public HIV/AIDS medical assistance |
| <input type="checkbox"/> Yes <input type="checkbox"/> No |

- | |
|---|
| <input type="checkbox"/> Receiving AIDS Drug Assistance Program (ADP) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No |

If No, Reason No (if applicable):

- | |
|---|
| <input type="checkbox"/> Applied; decision pending |
| <input type="checkbox"/> Applied; client not eligible |
| <input type="checkbox"/> Client Did Not Apply |
| <input type="checkbox"/> Insurance Type N/A for this Client |
| <input type="checkbox"/> Client Doesn't Know |
| <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> Data Not Collected |

If No, Reason No (if applicable):

- | |
|---|
| <input type="checkbox"/> Applied; decision pending |
| <input type="checkbox"/> Applied; client not eligible |
| <input type="checkbox"/> Client Did Not Apply |
| <input type="checkbox"/> Insurance Type N/A for this Client |
| <input type="checkbox"/> Client Doesn't Know |
| <input type="checkbox"/> Client Refused |
| <input type="checkbox"/> Data Not Collected |

T-Cell (CD4) Count Available:*

- | | | | | | |
|--|--------|-------|----------------|-------|---|
| <input type="checkbox"/> Yes | Date:* | _____ | T-Cell Count:* | _____ | <input type="checkbox"/> Client Report |
| <input type="checkbox"/> No | | | | | <input type="checkbox"/> Medical Report |
| <input type="checkbox"/> Client Doesn't Know | | | | | <input type="checkbox"/> Other |
| <input type="checkbox"/> Client Refused | | | | | |
| <input type="checkbox"/> Data Not Collected | | | | | |

Viral Load Available:*

- | | | | | | |
|---|--------|-------|--------------|-------|---|
| <input type="checkbox"/> Available | Date:* | _____ | Viral Load:* | _____ | <input type="checkbox"/> Client Report |
| <input type="checkbox"/> Not Available | | | | | <input type="checkbox"/> Medical Report |
| <input type="checkbox"/> Undetectable | | | | | <input type="checkbox"/> Other |
| <input type="checkbox"/> Client Refused | | | | | |
| <input type="checkbox"/> Data Not Collected | | | | | |

Financial Assessment:*

Cash Income:* ☐ Yes ☐ No

- ☐ Earned Income \$ _____
- ☐ Private Disability Insurance \$ _____
- ☐ Unemployment Insurance \$ _____
- ☐ Worker's Compensation \$ _____
- ☐ Pension From Former Job (VA Included) \$ _____
- ☐ Supplemental Security Income \$ _____
- ☐ Social Security Disability Income \$ _____
- ☐ Retirement (Social Security) \$ _____
- ☐ Alimony \$ _____
- ☐ VA Service-Connected Disability \$ _____
- ☐ VA NonService-Connected Disability \$ _____
- ☐ TANF \$ _____
- ☐ Child Support \$ _____
- ☐ Other Income \$ _____

Non Cash Benefits:* ☐ Yes ☐ No

- ☐ Food Stamps/Money for Food on Benefits Card
\$ _____
- ☐ Special Supplemental Nutrition Program (WIC)
- ☐ TANF Child Care Services
- ☐ TANF Transportation Services
- ☐ Other TANF Funded Services
- ☐ Section 8, Public Housing, Other Rental Asst. (PSH)
\$ _____
- ☐ Temporary Rental Assistance (RRH) \$ _____
- ☐ Other Source